Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6002109	B. WING		03/17/2016	
	PROVIDER OR SUPPLIER	1000 PAL	•	FATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
S 000	Initial Comments		S 000			
	Annual Licensure a Licensure Survey f	and Certification Survey or Sub Part S:SMI				
S9999	Final Observations		S9999			
	STATEMENT OF L	ICENSURE VIOLATIONS:	A.T. I. M. A.			
	300.1230b) 300.1230d) 300.1230j) 300.1230l) 300.1230k)					
	b) The number care who are need facility shall be residents, and shathe number of hou needs on each shid) Each facility care staff by:  1) Determining	Direct Care Staffing er of staff who provide direct ed at any time in the based on the needs of the ll be determined by figuring rs of direct care each resident ft of the day.  y shall provide minimum direct g the amount of direct care meet the needs of its				
	ratios set forth in the j) Skilled Nur For the purpose of and "personal care staff listed in substitutions."	rsing and Intermediate Care f this subsection, "nursing care" e" mean direct care provided by ection (f).		Attachment A Statement of Licensure Vi	olations	
	5) Effective J staffing ratios shall	anuary 1, 2014, the minimum I be increased to 3.8 hours of				

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Illinois Department of Public Health
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
IL6002109		IL6002109	B. WING		03/17/2016		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
PALM TE	RRACE OF MATTOO	N 1000 PALI MATTOON	VI I, IL 61938				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
S9999	Continued From pa	ge 1	S9999				
	needing skilled care personal care each intermediate care. Act)	al care each day for a resident e and 2.5 hours of nursing and day for a resident needing (Section 3-202.05(d) of the					
	personnel needed t	ne the numbers of direct care to staff any facility, the dures shall be used:					
	The facility residents needing s	shall determine the number of skilled or intermediate care.					
	shall be multiplied I	or of residents in each category by the overall hours of direct day for each category.					
	the residents in each	hours of direct care needed for ch category will give the total e needed by all residents in the					
	direct care needed amount of licensed provided during a 2 total minimum hou 10% will give the m	the total minimum hours of by 25% will give the minimum I nurse time that shall be 24-hour period. Multiplying the rs of direct care needed by hinimum amount of registered all be provided during a 24-hour					
	Least 75% of the M The remaining 75% direct care hours n identified in subsect documented that the	% of the minimum required hay be fulfilled by other staff ction (f) as long as it can be hey provide direct care and as re is provided in accordance					

6899

Illinois Department of Public Health STATE FORM

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Illinois Department of Public Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
vida, 1		IL6002109			03/1	03/17/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
DAI M TI	ERRACE OF MATTOO	N 1000 PALI				
I VEIN II		MATTOON	N, IL 61938			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	6) The amount subsections (I)(4) at Dividing the total number of hours ea (usually 7.5 or 8 houpersons needed to shall not include timescheduled in-service residents used to cabased on the facility	t of time determined in and (5) is expressed in hours. Imber of hours needed by the ch person works per shift ars) will give the number of staff each shift. Calculations are for scheduled breaks or training. The number of alculate staff ratios shall be				
	of 25% of nursing a provided by licensed nursing and persona registered nurses. Flicensed practical nuexcess of these requisitions that the satisfy the remaining personal care time in 3-202.05(e) of the AThis requirement is	nd personal care time shall be d nurses, with at least 10% of al care time provided by Registered nurses and urses employed by a facility in uirements may be used to g 75% of the nursing and requirements. (Section				
	failed to meet staffir and direct care for 7 reviewed. This failur all 134 residents in 15 Findings include: On 3/16/16, E1 Adm spreadsheet dated a spreadsheet docum for that period for 13 8.71 skilled residents. The total	ng requirements for nursing of 14 consecutive days are has the potential to affect the facility.  Ininistrator provided a staffing 2/29/16 through 3/13/16. The ents the average daily census 34 residents comprised of as and 127.29 intermediate minimum hours for direct atted at 351.32 hours in a 24				
	requirements. The hours needed for lic are 87.83 hours. The	total minimum number of ensed nurses per 24 hours ne total minimum number of egistered Nurses (RN) in a 24				

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STATE FORM VFEO11 If continuation sheet 3 of 4

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		IL6002109	B. WING		03/1	17/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY.	STATE, ZIP CODE	***************************************	
		1000 PAL				
PALM TI	ERRACE OF MATTOO	N	N, IL 61938			
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S9999		-	S9999			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3 hour period are 35 hours. The facility staffing spreadsheet and working schedules document the following staffing failures: 3/2/16 - Registered Nurses - 23.75 hours, a shortage of 11.25 hours 3/3/16 - Registered Nurses - 31.0 hours, a shortage of 4.0 hours 3/4/16 - Registered Nurses - 30.5 hours, a shortage of 4.5 hours 3/5/16 - Direct Care Staff - 322.69 hours, a shortage of 28.63 hours 3/6/16 - Registered Nurses - 24.0 hours, a shortage of 11.0 hours; Direct Care Staff - 325.69 hours, a shortage of 17.63 hours 3/12/16 - Direct Care Staff - 307.84 hours, a shortage of 43.48 hours 3/13/16 - Registered Nurses -34.0 hours, a shortage of 43.48 hours 3/13/16 - Registered Nurses -34.0 hours, a shortage of 1.0 hour; Licensed Nurses-79.5 hours, a shortage of 83.39 hours. On 3/17/16, at 10:50AM, E19, Human Resources/Certified Nurse Assistant stated the Assistant Director of Nursing (ADON) hours are included in the total number of Registered Nurse hours on the spreadsheet and are correct. On 3/17/16, at 12:00 PM, E1, Administrator, stated E1 is in agreement with staff shortages for RN 's on 3/2/16, 3/3/16, 3/4/16, 3/6/16, 3/13/16; and shortages for Licensed Nurses on 3/13/16; and shortages for Licensed Nurses on 3/13/16; and shortages for Licensed Nurses on 3/13/16; and shortages for Direct Care Staff on 3/5/16, 3/6/16, 3/12/16, and 3/13/16. E1 also confirmed the staffing spread sheet and other staffing documents given were correct. The facility census documented on the Resident Census and Conditions of Residents dated 3/14/16 is 134.					

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STATE FORM 6899 VFEO11 If continuation sheet 4 of 4